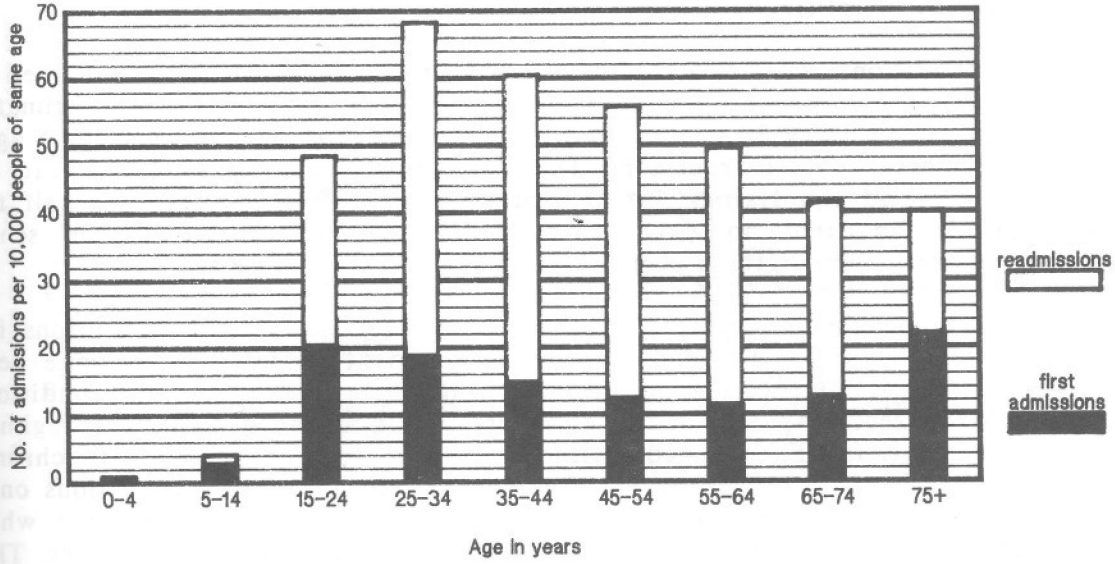


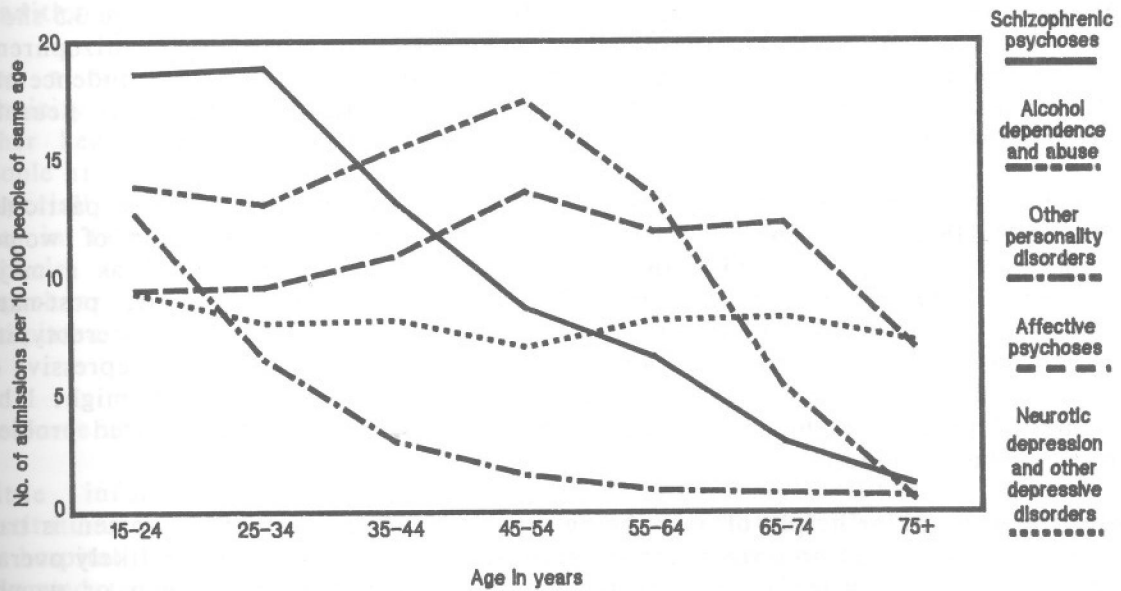
Infogram 3.3 ADMISSIONS TO INSTITUTIONS FOR THE MENTALLY ILL
(Rates by age and type of admission, 1984)



Note: Rates do not include admissions attributable to intellectual handicap.

Sources: Department of Health, Mental Health Data 1984,
Department of Statistics, Population Estimates 1984.

Infogram 3.4 ADMISSIONS TO INSTITUTIONS FOR THE MENTALLY ILL
(Rates for major conditions by ages, 1984)



Source: Department of Health, Mental Health Data 1984.

The rates of admission for alcohol-related disorders and the affective psychoses increase with age until people become elderly (over 65 years). The rates of admission for alcohol disorders increase because they are "chronic relapsing disorders", which often necessitate readmission after an initial discharge. And the rates for the affective psychoses increase because they are late in onset by comparison with the other main causes of admission.

The above conditions are less significant among the elderly (people aged over 65 years) as causes of first admission. For this age group, it has been estimated that at least one in every 20 people aged 65 years or more and one in every 5 aged 80 years or more suffers from some form of senile dementia of a moderate or severe nature (Todd and Haines, 1983). Not surprisingly, then, more than half the elderly people admitted to psychiatric institutions are admitted for senile disorders, and over 90% of these people are aged 75 years or more.

Though elderly people are most commonly admitted to psychiatric institutions for senile disorders, many of the elderly who are resident in institutions have been there for many years and were admitted when younger because of chronic conditions such as schizophrenia, not for senile disorders. With changed treatment regimes, especially medication, and changed attitudes towards keeping people with chronic disorders in institutions, fewer people are now admitted for such conditions on a long-term basis. Thus the numbers of elderly long-stay patients admitted when young, for chronic conditions, can be expected to decline in future years. This will result in an increase in the proportion of those first admitted at an older age for senile and pre-senile disorders.

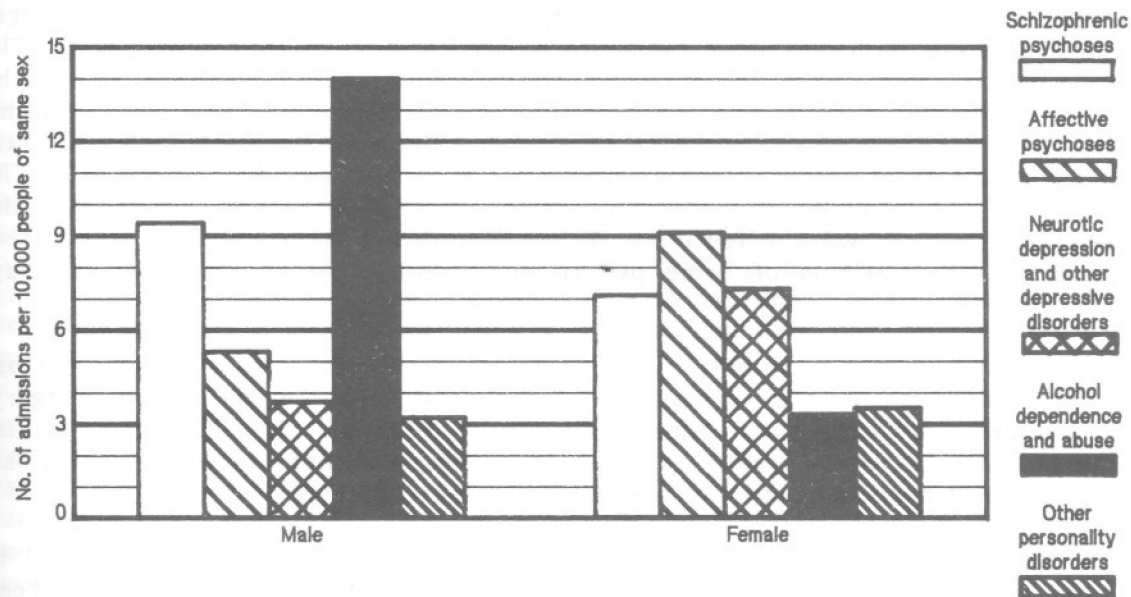
Since 1977, the average length of stay before discharge, for all conditions and in all psychiatric institutions, has decreased significantly: from 161 days in 1977 to 116 days in 1984. Length of stay in psychiatric hospitals is, however, about five times longer than the 25-day average stay in psychiatric units.

Reasons for admission are closely related to sex, as well as age. Males and females tend to be admitted to psychiatric institutions for generally different reasons and at quite different rates. Overall, women are admitted at a lower rate than men (39 per 10,000 women compared with 44 per 10,000 men). Infogram 3.5 shows that women are a little less likely than men to be admitted for schizophrenic conditions and much less likely than men to be admitted for alcohol dependence and abuse. Women are, however, admitted at a greater rate than men for neurotic depression and other depressive conditions, and for affective psychoses.

To some extent this general pattern of differences in rates by sex for particular disorders reflects differences in lifestyle. For example, the isolation of women in suburban environments with their young children has been cited as a major causative factor leading to depressive disorders and in particular, post-natal depression (Mental Health Foundation of New Zealand 1983). Sex-role stereotyping may also be an important factor leading to women being diagnosed as depressive or neurotic. Research indicates, for instance, that health professionals might label a woman depressive rather than diagnose her as having an alcohol-related problem (Howden-Chapman, 1984).

While the general principle of men being admitted more often than women is true within both Maori and non-Maori ethnic groups, Maori women are more likely overall to be admitted to psychiatric institutions than either non-Maori men or women (Infogram 3.2). This fact suggests that although sex roles do influence psychiatric admissions, as does age, other factors also affect the risk or chance

Infogram 3.5 ADMISSIONS TO INSTITUTIONS FOR THE MENTALLY ILL (Rates for major conditions by sex, 1984)



Source: Department of Health, Mental Health Data 1984.

of admission. Maori people are admitted for much the same types of conditions in similar proportions to non-Maori people, but they are admitted at a far greater rate. Racial stereotyping and cultural insensitivity may be a factor in explaining this difference as may the relatively deprived economic and social conditions in which many Maori people live.

How a person is referred for in-patient psychiatric treatment varies with the ethnicity of the individual. Non-Maori people are most frequently referred from other health services, such as general practitioners and public hospitals. Maori people are more likely to be admitted following referral from non-medical agencies (especially law enforcement agencies), or following self referral. Maori people are, in fact, more than twice as likely to be referred from law enforcement agencies as non-Maori people (Dawson et al, 1986). Thus the high rate of apprehension for criminal offending amongst Maori people could, to some extent, be associated with their over-representation in psychiatric institutions.

Resource usage

Little information is available on the costs of providing psychiatric institutions. The funding for their operation is included in the general grants to hospital boards who decide individually how much of those funds should be allocated to psychiatric services. The amount spent will, therefore, vary between one board and another. Within any board's expenditure it is difficult to identify the total amount spent on psychiatric services.

There are considerable differences in the types of service provided by the various facilities. General hospital psychiatric units are designed for acute admissions, not for those in need of committal or long-term care nor for those with chronic relapsing disorders. These people are more likely to be admitted and readmitted to psychiatric hospitals. Psychiatric hospitals are likely to have older, larger and less suitable buildings than the more newly established psychiatric units. The staff-to-patient ratio is lower in psychiatric hospitals and, in some cases, the hospitals are isolated from major population centres. This poses problems in terms of transport, staff recruitment and service development, especially pre-hospital assessment and after-care or daycare services (Dowland and McKinlay, 1985). The strain of having to work in such conditions can be marked and may affect the capacity of staff to work effectively. These factors are likely to have a negative outcome for the patients of some psychiatric hospitals (Dowland and McKinlay, 1985).

Pugh (1985) calculated that psychiatric inpatient care costs approximately \$90 per day. By comparison with other health services, this is a low daily cost. Surgery, for instance, costs over three times as much at \$275 per day. However, mental illness normally involves much longer stays in hospital than do other conditions, so the total cost per illness-episode is likely to be much greater.

The number of available psychiatric hospital beds has been reduced from 6,821 in 1978 to 5,418 in 1985 (Department of Health 1978c, 1985c) although, as has been shown earlier, the number of admissions has increased slightly. The reduction in beds is due to changes in approaches to the care of the mentally ill, with long-term institutional care no longer being seen as the usually desirable course. Instead people are admitted to institutions for assessment, and for the development of treatment programmes to stabilise their conditions so that they can return to the community. As a consequence, there are shorter periods of stay in institutions. However, some people are still admitted for long-term care, and the likelihood of this increases with age.

The availability of psychiatric hospital beds has been shown to affect rates of admission. Malcolm (1984) showed that hospital boards which have high numbers of psychiatric beds relative to their population tend also to have higher rates of admission, though there is nothing to suggest a greater incidence or severity of disorder in those areas. Hence the availability of institutional services may act in some circumstances as a disincentive to the development of community-based services and as an encouragement to make greater use of institutional services.

Effectiveness

The outcomes of inpatient care for people with mental illness are not easy to assess. The goals of the services are more often assumed than expressed, especially with the long-established services. However it seems there has been a shift in purpose, with a growing recognition that many psychiatric disorders cannot be cured and must be managed or controlled. The implicit objectives of institutions for the mentally ill have changed from asylum, or separation from the community, to treatment and community integration. Thus, in relation to disorders such as alcoholism and schizophrenia, there is acknowledgement that relapse is likely and overall progress relatively slowly made.

The various facilities for the treatment of people with alcohol-related problems tend to operate programmes aimed at helping the individual to accept the reality

of their problem and to explore ways of overcoming it, usually with the goal of abstinence. They have shown a capacity to adapt the orientation of their programmes from a mainly middle-aged clientele to a younger age group and now have a more individualised approach to treatment. Attempts are made to involve the families of people in the treatment process but resources for this are limited. It is an area that deserves further attention.

Many people suffering from major psychiatric disorders, such as functional psychotic disorders, can be treated both more effectively and more economically in the community than they can in an institution (Hoult et al, 1983). Hoult's study also indicated that the relatives of psychiatric patients tend to prefer community care. Such care does, however, require at least the same level of resources, in terms of professional support and consequent funding, as does hospital care. The components of community care in the Hoult study were 24-hour availability of professional staff, crisis intervention, continuity of care over a long term, the providing of care and support to the patient in the community, the teaching of living skills to patients, and the educating and training of carers. To be successful, community care must have a high patient/professional staff ratio and ready access to professional services at all times. To date, that level of resource commitment has only rarely been available for any length of time. Hoult warns that, "if community care is opted for purely because it is the 'cheaper' mode of treatment and attention is not paid to the quality of community treatment, then the consequences will be negative rather than positive." (Hoult et al, 1983 p. 166).

There are examples where with careful planning and preparation there has been success. Sunnyside Hospital in Christchurch has developed the means to relocate patients from the hospital to the community with positive results for them and for their families (Sheerin and Gale, 1984). Key factors in making the transition effective seem to be adequate preparation of the patients for the change, good community support and the possibility of ready readmission if needed. Also important is the education of staff about the changes and reassurance that their position is not threatened. The reality of community care is that it is unlikely to need fewer staff resources but that staff will need to learn new skills for a changing care environment.

The reduction in length of stay, and in the number of psychiatric beds available, has been made possible by using hospital admission to stabilise the person's condition and then discharging them into the community. Unless there are adequate services in the community to support people, this practice is likely to be ineffective for both the patient and the health administrators because rapid deterioration in the person's condition and consequent strain on caregivers will lead to early readmission. It is also important that the members of communities are ready to accept people with mental illness. A number of studies have indicated widespread fear and rejection of the mentally ill amongst "normal" community members (Walkey et al, 1981).

Acceptability

Psychiatric treatment in whatever form has long been the subject of debate, with particular emphasis being placed on people's rights to lead their lives as they wish, without being forced to conform to particular styles of behaviour or being deprived of the freedom to participate in the wider society.

Because of the particular vulnerability of people suffering from mental illness, official visitors are appointed in psychiatric hospitals and patients may express concerns to them about the acceptability of the care they receive. However, a wider public concern about the rights and well-being of psychiatric patients has been stimulated by the work of such groups as the Mental Health Foundation and the Schizophrenia Fellowship. This has led to reassessment of processes in mental health services and to the involvement of consumers in some areas of planning and control.

A departmental review of mental health services has condemned some facilities and practices within hospitals (Department of Health, 1986b). It suggests that improvements will be made by the provision of more resources, including staff, and by hospital boards taking a more planned approach to psychiatric hospital care. In particular, it comments on the lack of statements of objectives drawn up by boards and hospitals and on the lack of services responsive to regional needs. Improved planning by managers is likely to be helped by the preparation of a national mental health policy, which itself has been proposed for some time, and by regional service guidelines.

The rising rate of Maori admissions has made the development of culturally sensitive programmes especially important for psychiatric hospitals. There is a need, especially, to realise that there are alternative, non-Western ways of viewing and experiencing health and illness (Dowland and McKinlay, 1985). The institutions' response to this has not been uniform but those hospitals which serve large Maori populations have begun to address their needs in a more culturally appropriate manner. Tokanui Hospital near Hamilton has perhaps gone furthest by establishing a unit run according to Maori procedures, and taking a holistic view of well-being with mental illness as one part of the total concept.

Key Points

- * Over recent years, numbers and rates of total admissions to institutions for the mentally ill have stabilised. This trend is in spite of steadily increasing Maori admission rates over the same period. The admission rate of Maori women is, for instance, far greater than either the non-Maori male or the non-Maori female rate and is still increasing. The Maori male rate is even greater.
- * Men are more likely to be admitted to psychiatric institutions than women, but for generally different types of conditions. Whilst men are admitted at high rates for alcohol dependence and abuse, women are more often admitted for depressive conditions.
- * Average lengths of stay in institutions for the mentally ill have decreased so that reductions in the numbers of beds provided have been possible.
- * Psychiatric units in public hospitals are generally new and have good staff/patient ratios. Psychiatric hospitals, however, are often old with large, inappropriately designed and isolated buildings. Further, there are indications that psychiatric hospitals are understaffed and have difficulty recruiting and retaining staff.
- * Although community care of the mentally ill can be more effective and acceptable to patients and relatives, it is unlikely to be cheaper than institutional care in terms of resource commitments, especially given the need for continuing access to professional staff and support services within the community setting.

CHAPTER 4: INSTITUTIONS FOR THE INTELLECTUALLY HANDICAPPED

Introduction

Intellectual handicap arises from a variety of causes and its identification is, to some extent, dependent on its severity. The most severe forms are often congenital and may be identified at, or relatively soon after, birth. Moderate and mild intellectual handicap may have a physical cause but environmental and social factors may also be involved. The less severe forms of intellectual handicap may not become evident until the person is subjected to increasing intellectual demands, usually when they start school.

The consequences and significance of intellectual handicap for a person's ability to participate in society, and their capacity for self care, is the result of both social and environmental factors, as well as the person's intellectual ability. Whether or not an intellectually handicapped person is ever likely to be admitted to an institution is, then, the result of both personal and social factors. This chapter looks at the institutions to which intellectually handicapped people are most likely to be admitted and examines the circumstances which increase the chances of admission.

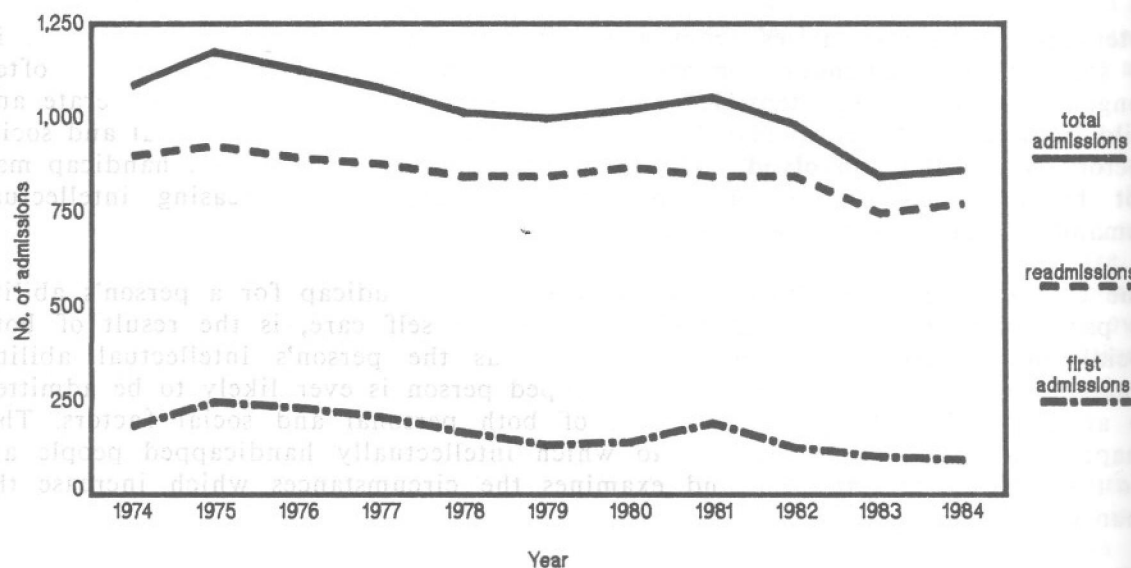
Who is in institutions for the intellectually handicapped?

A survey of intellectually handicapped people living in New Zealand in 1971 showed that almost 40% of them were in either psychiatric or psychopaedic hospitals (Morrison et al, 1976). The situation had changed little by 1981 when a study in North Canterbury showed that although proportionately more intellectually handicapped people were living in community residential facilities (such as group homes and hostels) than was the case in the earlier national study, this was associated with a decrease in the percentage living in their family home rather than a decrease in the proportion living in hospitals. Hospitals still provided for nearly 40% of intellectually handicapped people (Prentice and Barnett, 1983).

There are four psychopaedic hospitals (that is, hospitals catering solely for people with intellectual handicap) in New Zealand. Between them they care for just over 50% of all intellectually handicapped people in hospitals. The remainder live in psychiatric hospitals throughout the country.

Although the proportion of intellectually handicapped people resident in institutions has shown little change, their numbers decreased by 16% between 1971 and 1983: from 4,329 in 1971 to 3,621 in 1984 (Department of Health, 1984a, 1983e). There has also been a corresponding decrease in the number and rate of admissions, which is related to the overall decline in births since the mid 1960s.

The numbers of both first admissions and readmissions to psychopaedic and psychiatric hospitals have been gradually decreasing since 1974, though there is considerable variation from one year to another (Infogram 4.1).

Infogram 4.1**HOSPITAL ADMISSIONS DUE TO INTELLECTUAL HANDICAP (1974-1984)**

Source: Department of Health, Mental Health Data 1974-1984.

The proportions of intellectually handicapped males and females in hospitals seem to be changing. Morrison et al (1976) reported that almost 54% of intellectually handicapped hospital residents were male, but by 1983 this had risen to 60% (Department of Health 1983a). The incidence of intellectual handicap in the total population is higher among males than among females (17.8 per 10,000 for males, compared with 15.1 per 10,000 for females (Morrison et al)), and this to some extent explains the higher percentage of intellectually handicapped people in hospitals who are male. Prentice and Barnett (1983) suggested that the generally higher incidence of identified intellectual handicap among males may reflect social attitudes toward achievement, with more expectations of success placed on males. Social attitudes may also play a part in the differences in placement of male and female intellectually handicapped people, with males perhaps more likely to have, or to be seen to have, behaviours which make them unsuitable for placement in community residential settings.

The likelihood of institutional admission increases with age. In the Morrison study, only 7% of intellectually handicapped children aged less than 14 years were in hospitals, whereas the figure rose to almost 56% for those aged 30 years or more. Prentice and Barnett showed that few of the very young are in hospitals in the North Canterbury region, but the proportion rises quite rapidly with age, especially once the school-age years are passed. In this study more than 60% of all intellectually handicapped people aged more than 30 years were in hospitals, with the figure rising to 80% of those over 60 years. This age pattern shows the influence of past policies when admission to hospital was regarded as the most appropriate course of action for all intellectually handicapped people. It also reflects the increased demands of adult intellectually handicapped people on their

carers, who are themselves ageing and may therefore be more susceptible to stress, sickness, and disability or death.

The other major determinant of hospitalisation of the intellectually handicapped is the severity of their disability. Morrison et al (1976) reported that, of the intellectually handicapped people in hospitals, 15% were mildly intellectually handicapped and 33% were moderately handicapped. These groups have received particular attention from the New Zealand Society for the Intellectually Handicapped (IHC) and hospital-based workers, and there has been a large drop in the numbers of them admitted. Many who had been long-term hospital residents have been integrated into community residential settings. At Mangere Psychopaedic Hospital this has meant that all the mildly handicapped residents have been discharged and the moderately handicapped group is constantly changing as they are admitted for only intermittent care. Beds are now used for short stays which may be aimed at assessment, at the development of individualised programmes, or to provide a break for carers (Board of Health, 1982). The same is likely to be true of other hospitals.

Most intellectually handicapped residents of hospitals have been in the hospitals for a long time. Watson et al (1985) report that 10% have been resident for less than one year, 75% for five years or more and 28% for 20 years or more.

Resource usage

The trend for psychiatric and psychopaedic hospitals to care for fewer intellectually handicapped patients as inpatients and to admit more people for short- rather than long-term care is likely to continue. Changes in policies of care, with their increased emphasis on community rather than institutional provision of long-term care, are influential in this but other factors are also operating. Laugeson (1978) concludes that although more intellectually handicapped children could survive because of lower infant mortality, the combined effects of various social and medical changes (such as the capacity to identify intellectual handicap in time to terminate the pregnancy) and the overall decrease in the number of live births means that there may be fewer intellectually handicapped children to care for in the future.

In terms of service development, however, those factors are somewhat counter-balanced by the influence of the ageing of the intellectually handicapped people born as part of the "baby boom". Increased age is associated with an increased rate of institutional admission. Of equal significance is the ageing of their parents, whose reducing capacity to care for them may lead to an upsurge in the numbers of intellectually handicapped people needing non-family care in the medium term.

In the short and medium term, hospitals can anticipate a greater proportion of their residents having profound levels of handicap. This, coupled with an increased demand for short stays for assessment and carer relief, will require changes in the ways the hospitals function. A particular goal should be to determine how their relief-care service can be made more acceptable to the families of the intellectually handicapped so that the high levels of stress borne by these families can be reduced (Chetwynd, 1985a).

The inclusion of the costs of hospital care for the intellectually handicapped in the general accounts of mental health services makes it difficult to work out the

financial aspects of this service. The cost for the 2,429 psychopaedic beds in 1979 was established as \$28,000,000 (Board of Health, 1982) but that is likely to be an underestimate because of the misclassification of beds. (The effect of such misclassification can be appreciated in the apparent increase from 2,664 psychopaedic beds in 1983 to 2,837 in 1984. In reality this change was due to the reclassification of beds in psychiatric hospitals which, though described as "psychiatric", had in fact been used for psychopaedic care.)

The annual cost of care per resident of the psychopaedic hospitals in the year ended 31 March 1985 was calculated at between \$22,670 and \$23,710 on average, and at \$25,850 for one psychiatric hospital (Controller and Auditor-General, 1985). This was considerably more per resident than the cost of care in community-based residential services provided by the IHC, which was calculated at \$12,900 for a child and \$14,700 per year for an adult. This is largely explained by the higher staff ratios in the hospitals, and reflects differences in their residents' needs for care. The difference is also partly attributable to the lower rates of pay which workers for IHC receive.

Effectiveness

Consistent with a change in attitudes to intellectually handicapped people's ability, and their right to participate fully in society, has been a change in the general goals of providing institutional care for the intellectually handicapped. The emphasis is now on providing assessment facilities, coupled with the development of training schedules which may be applied outside the hospital setting, and on providing short-term stays to provide relief to the intellectually handicapped person's carers. Long-term care is considered suitable only for the severely or multiply handicapped person.

There have been few evaluations of the hospitals' performance in developing effective assessment and training schedules but Webb (1985) reported research which showed that the greatest difference between the community units and hospitals studied was that the latter were more likely to have consistent, daily training programmes aimed at both remedial training and ongoing behavioural development. She points out that the intellectually handicapped are permanently disabled and therefore in need of lifelong training and support. Her research also showed that in all care situations studied, the greater the degree of handicap the lower the standard of service in terms of staff/resident contact and resident-oriented management. In terms of improving the environments of intellectually handicapped people, those in which the older and more severely handicapped live warrant most attention.

Government-funded care can be provided for up to four weeks in a year to enable the carers of intellectually handicapped people (and other dependants) to have a break from their responsibilities. This can be by placement of the dependent person in a public hospital or private institution or by payment for someone to assume care in the person's normal community setting. However, Chetwynd (1985a), in a study of factors contributing to stress on mothers caring for an intellectually handicapped child, found that some families did not use this option and went without holidays altogether. She does not discuss the reasons for this but a study by the Society for Research on Women (1979) found that many people caring for disabled people felt that hospital care was no substitute for the type of care they provided.

Acceptability

There has been a significant change in approach to the care of the intellectually handicapped in recent years. The earlier view of long-term institutional placement as the most desirable method of care has been replaced with a view of it as appropriate only in cases where the severity of handicap makes community-based care impossible. A 1974 study concluded that nearly 54% of the intellectually handicapped residents of psychopaedic and psychiatric hospitals were capable of living in a more independent environment (Booth and Jeffery, 1974).

The IHC, which was formed by parents of intellectually handicapped people in 1949, has been very influential in bringing about a change in orientation to the care of the intellectually handicapped and in providing community-based facilities for them. Their community-based residential services catered for 15.5% of all the intellectually handicapped in 1983 (Caseley, 1985).

The other major alternative to institutional care for intellectually handicapped people is care provided by their families. Despite a variety of support structures having been set up to assist families in this role, caregivers have been shown to suffer disadvantages relative to other families in terms of their financial well-being, their general capacity to participate in the normal life of their community, and in the levels of stress they experience (Society for Research on Women, 1979; Chetwynd, 1985a, 1985b).

Though fewer people are being admitted to long-term care, and although many who were formerly in hospitals have been moved into community settings, Jack (1985) describes this as "very limited progress" and says that with current policies and practices it will be 50 years before most of those presently in hospitals will have been moved into the community. The unavailability of suitable community settings is the main impediment to change. There are always likely to be a sizeable group of intellectually handicapped people who, because of the extent of their disabilities, both physical and intellectual, will need the intensity of care provided only in hospital settings.

The question of which government department should be responsible for the care of intellectually handicapped people has also been questioned. Intellectually handicapped people are not sick but disabled. Studies show that an emphasis upon training is more effective in caring for them than an emphasis upon nursing (Jack, 1985). It therefore seems appropriate that responsibility for such services should be transferred to the Department of Education, although Jack suggested the Department of Social Welfare. There is, in fact, already some overlap with the Department of Social Welfare, in that the Department provides the funding for short-stay care (which provides relief for the carers of intellectually handicapped people).

Shared responsibility between departments should be avoided if possible as it presents problems for the families of intellectually handicapped people. It forces them to deal with a variety of bureaucratic systems relating to their child's health, education, and residential care.

Key Points

* The number of severely intellectually handicapped infants being admitted to hospitals on a long-term basis is gradually declining. It is, however, unlikely

that the number and proportion of intellectually handicapped people cared for on a long-term basis in hospitals will decrease in the medium term. The number and proportion may even increase. This is because of the ageing of the population and the ageing of the parents caring for large numbers of intellectually handicapped people born during the "baby boom".

* Increasingly, new admissions of young intellectually handicapped people to hospitals are for short- rather than long-term stay, and are intended for assessment or for the relief of carers.

* While community-based care is likely to be cheaper for the state, hospital boards, and area health boards than institutional care, this is because of the sacrifices (either of pay or of life opportunities), of those who do the caring in the community.

* Intellectually handicapped people are not sick but disabled. A planned and continuous programme of training is the most effective way of caring for them.

CHAPTER 5: INSTITUTIONS PROVIDING SUBSTITUTE CARE FOR CHILDREN

Introduction

In New Zealand, the role of primary carer of a child is almost always exclusively accorded to the child's parents and in particular to the mother. The welfare of the child is in large part dependent upon parental ability to provide for the child's needs. Thus the well-being of the child depends upon the well-being of the parent(s) (Beautrais et al, 1984).

When parents cannot or will not take this responsibility, a variety of state and voluntary organisations may become involved to ensure the child is cared for. Whether the agency is governmental or voluntary, it will usually attempt to place the child or children concerned in a community-based setting, such as a foster home. For some children, however, placement in an institution becomes necessary. The reasons for institutional placements and the characteristics of children affected are discussed in this chapter.

Children in the care of the Department of Social Welfare (DSW)

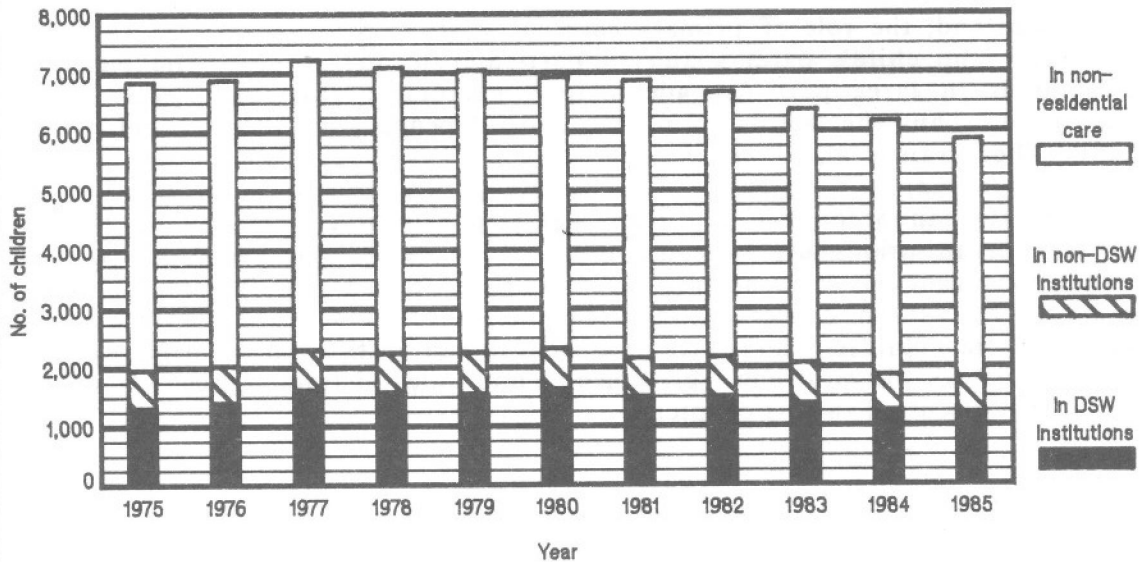
Where parents cannot or will not provide adequate care or control for their children, the Department of Social Welfare has the responsibility to ensure the children are cared for. Infogram 5.1 shows that the number of state wards (that is, children for whom the state has parental responsibility whether by court order or by agreement with the children's natural parents) has been steadily declining over recent years. If the state takes responsibility for care, the child will not necessarily be admitted to an institution. Infogram 5.1 also shows that only a minority of children in state care are in institutional care (31% during 1985). Most state wards continue living with their parents or relatives, or are placed in foster care.

Those children most likely to come into the care of the Department of Social Welfare are aged more than 10 years; few state wards are aged less than 5 years. This pattern has become accentuated over recent years, with an increasing proportion of older state wards and a decreasing proportion of younger state wards (Infogram 5.2).

Of the majority of children in the Department's care who are aged more than 10 years, a large proportion are more than 15 years old (40% in 1984). Even though young people of this age have certain freedoms, such as freedom from compulsory education, in some circumstances they are still felt to be in need of adult supervision. The guardianship and supervisory powers available to the Director-General of Social Welfare may continue until the person concerned is 20 years of age. If people aged more than 17 become liable to other forms of supervision, such as supervision by the Probation Service, they are likely to be discharged from Department of Social Welfare care.

The declining numbers of state wards over recent years probably reflect a combination of factors including a falling birth rate, the greater social acceptance of ex-nuptial birth, and more readily available financial support for single parents. They also reflect the introduction, in 1981, of the Department of Social Welfare's policy "Planning for Children in Care". This policy requires that when the Department is involved in providing or overseeing care for a child, a

Infogram 5.1 CHILDREN IN THE CARE OF THE DEPARTMENT OF SOCIAL WELFARE (1975-1985)



Source: Department of Social Welfare, Annual Reports 1975-1985.

social worker develops a clear plan of action for the child's future and this plan is periodically reviewed. Such plans and purposefulness have been a significant factor in reducing the numbers of children admitted to care.

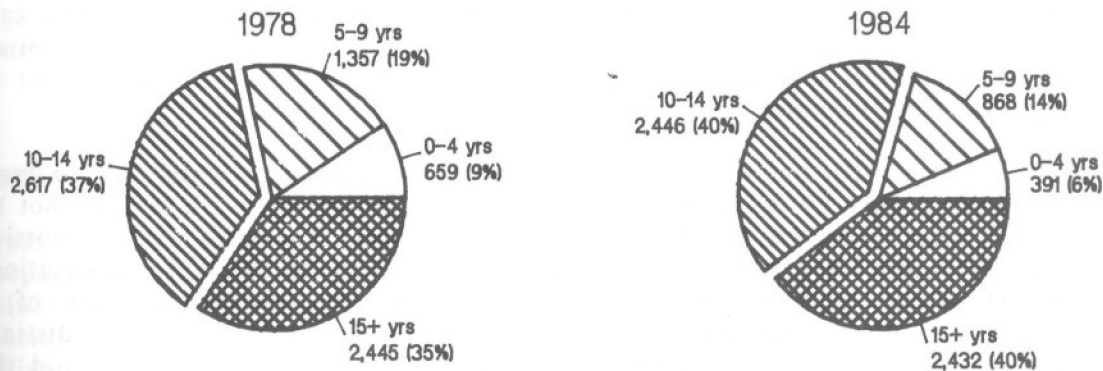
As well as the falling rates of admission to care, there has been a decline in the number of care orders imposed by the courts: from 87% of all state wards in 1975 to 75% in 1985. This is likely to be due to a greater emphasis on prevention, and to the emphasis on working with families, rather than taking over the responsibilities of families. The rise in the number of children admitted to care with the agreement of their parents (1,008 in 1985 compared to 519 in 1975) is indicative of a sharing rather than a controlling attitude.

The reasons for the admission of children into care are not well reported. A survey carried out in 1971 is probably the most comprehensive study of young children admitted to care by guardianship order (MacKay, 1981). The study found that the admission of young children was usually because of neglect or indigence (that is, being without an adult willing or able to accept responsibility for the child's maintenance). For older children, misbehaviour and the perception that the child is beyond the control of its parents become more significant as reasons for admission.

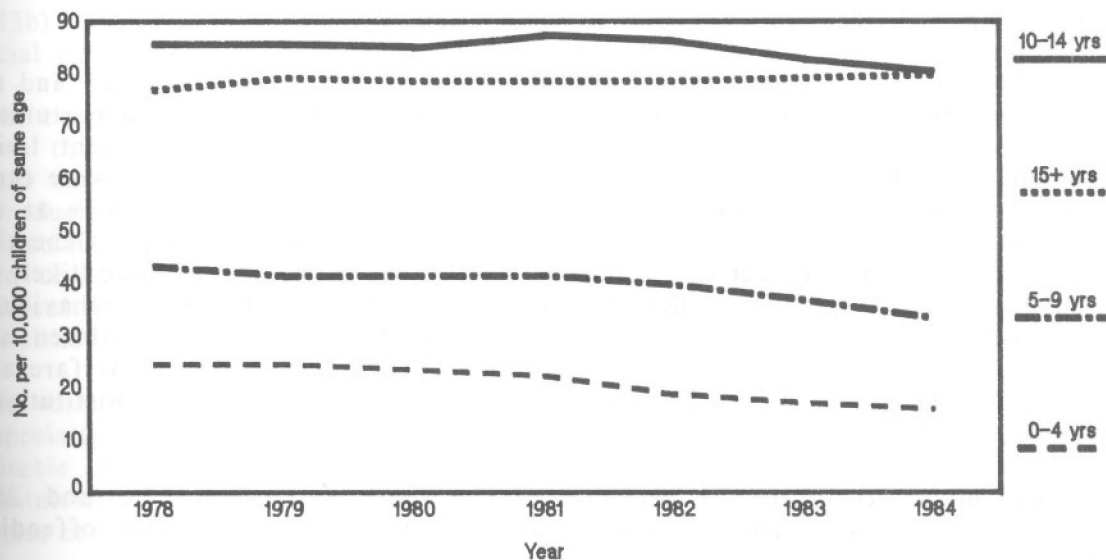
It is not possible to determine from currently available information how long a child is likely to remain in care. MacKay's study showed that five years after being admitted to care, 72% of children of all ages were still in care, as were 88% of those aged between two and four years at the time of being admitted to care. This does not mean, however, that these children are likely to be in institutional care: most are in foster care.

Infogram 5.2 CHILDREN IN THE CARE OF THE DEPARTMENT OF SOCIAL WELFARE (1978-1984)

a) No. Of Children, By Age, In The Care Of The Department of Social Welfare



b) Rate Of Children, By Age, In The Care Of The Department of Social Welfare



Sources: Department of Social Welfare, unpublished data,
Department of Statistics, Population Estimates 1978-1984.

Children in Department of Social Welfare institutions

In 1962, 23% (810) of the children in the care of the Department of Social Welfare were in some form of institution (whether residential institutions, special schools, private institutions, psychiatric institutions, hospitals or boarding schools). This figure rose proportionately and absolutely to 33% (2,306) during 1980 but by 1985 it had dropped to 31% (1,807). The growth between 1962 and 1985 must be seen against the near-doubling of the total number of children in the care of the Department of Social Welfare. More significantly, a change occurred in the type of institution to which children were admitted. The number of children placed in short-term institutions, in special schools, in extended care institutions and, most markedly, in psychiatric and psychopaedic hospitals declined. The greatest change was in the growth in the number of Department of Social Welfare family homes.

Family homes cater for small numbers of children in residences which differ from ordinary housing only by being somewhat larger than most. They are staffed not by professional social workers but by people whose principal employment is outside the home. They provide a more "normal" environment than do the larger institutions and are especially appropriate for older children for whom prospects of a fostering placement are limited. The adaptability of family homes is a distinct advantage as they can cater for small groups with special needs and can avoid the separation of children from their siblings.

The type of residential institution a child is admitted into is related to the age of the child. Few children in departmental care who are aged less than five are actually cared for in an institution of any kind (only 16%, or 36 children, during 1984). Most of these children were to be found in Department of Social Welfare family homes.

As children grow older, aspects of control as well as care become explicit and the rate of institutional placement increases. Further, fewer fostering opportunities are available for older children, though some are placed in independent living arrangements such as flats. During 1984, 22% of 9-year-old state wards were cared for within residential institutions with the proportion increasing to 47% at the age of 14 and declining to 27% for those aged more than 15 years. Generally, there is a cumulative effect operating in which increasing age is more likely to be associated with previous experience of residential care and with behavioural difficulties. There has also been an increase in the numbers of children and young people remanded to the custody of the Department of Social Welfare and placed in institutions: from 5% (of all children in departmental institutions) during 1975 to 8% in 1985.

Boys are more likely to be in institutions than are girls (33% and 26% respectively in 1984). This reflects differences in male and female offending patterns.

The Department of Social Welfare does not routinely collect information on the ethnicity of children taken into its care but in the year ended 31 December 1984, 51% of the 1,368 children coming into the care of the Department of Social Welfare were Maori (Department of Social Welfare unpublished statistics). Once in care, Maori children seem much more likely to be admitted to some form of institutional care, especially in the Auckland area. The Ministerial Advisory Committee report on institutional racism (1985) showed that 62% of children in residential homes in the Auckland area were Maori. Further, the population of children in institutions

who are Maori appears to have been rising. In 1959, Maori children made up "only" 25% of boys admitted to the Owairaka Boys Home. By 1969 the proportion had risen to 70%, and by 1978 to 80% (Department of Social Welfare, 1982).

As has already been noted older children and especially older boys are more likely to be admitted to institutional care because of behavioural problems or delinquency. Of the children admitted into the care of the Department of Social Welfare, Maori children are older (on average) than non-Maori children and are more likely to have come to the Department's notice because of misbehaviour. Although data is not available to support a conclusion that this is the reason for higher rates of admission to institutions, there is subjective support for this conclusion (Department of Social Welfare, 1982b).

Children in voluntary agency institutions

From the material provided in the Directory of Residential Facilities for Children (Department of Social Welfare, 1983b) it seems that, at least in principle, voluntary agencies provide care for children of all ages. However, only two specialise in the care of disturbed children, 29 (45%) have minimal facilities for caring for disturbed children, and 33 (51%) describe themselves as being able to care for a "moderate proportion" of disturbed children.

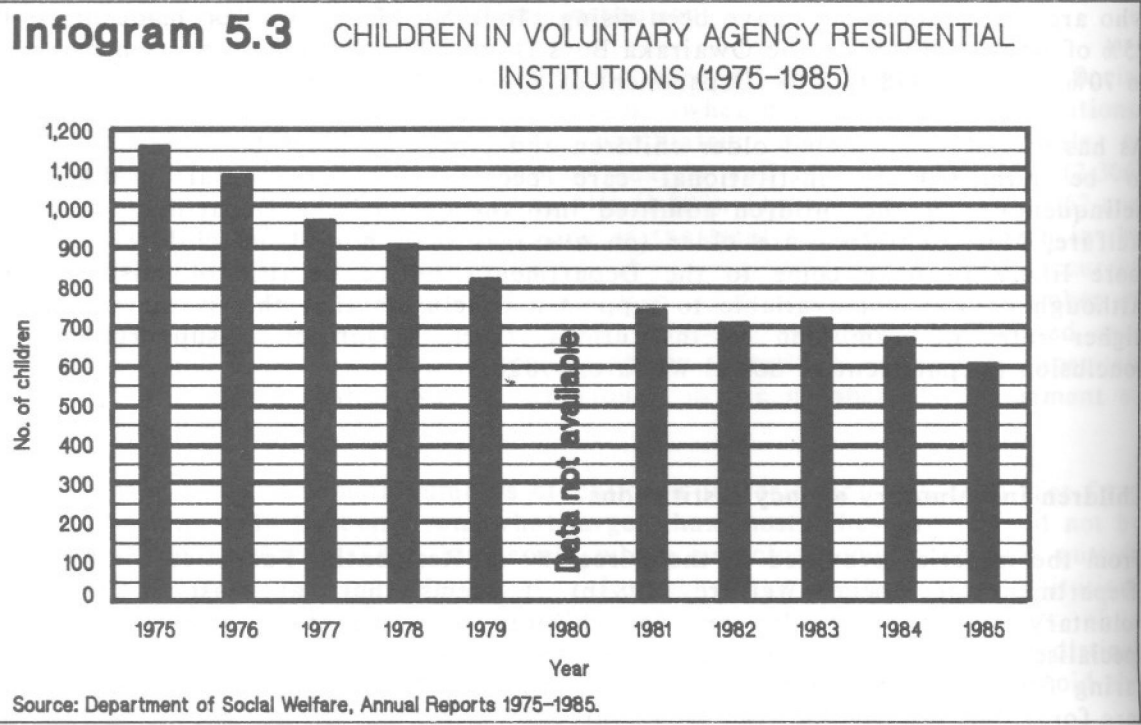
As at 31 March 1985, a total of 603 children (of whom 36% were state wards) were being cared for by 36 voluntary agencies in a total of 62 residential institutions. These 62 institutions could potentially accommodate a maximum of about 900 children if used to their full capacity (Department of Social Welfare, 1983b). Only 9 homes, however, accommodated more than 15 children (Department of Social Welfare, unpublished statistics).

Over the last 20 years the number of children cared for by voluntary agencies has more than halved (Infogram 5.3). This reflects changes in social attitudes to child care, lower fertility rates and the impact of social policy, especially the introduction of the Domestic Purposes Benefit (DPB). It also reflects the financial costs of providing residential care for children. A report of an inquiry into childcare related the reduced role of voluntary agencies to the financial difficulties they face because of what was seen as inadequate government support for either preventive or residential care (Cahill et al, 1977).

The voluntary sector, like the state, has moved away from institutional childcare (especially large children's homes) because of a feeling that they do not provide suitable environments for children. Thus, although the number of children's homes administered by voluntary agencies has remained relatively constant, many large homes have closed and several much smaller institutions have opened.

The characteristics of the children in these institutions are not known in any detail. McDonald (1976) suggested that voluntary agencies were likely to provide long-term care for younger European children who were admitted because of family problems. The state system by contrast was more likely to care for non-European children who were often older and admitted because of misbehaviour.

Information supplied by the Salvation Army about the residents of its children's homes gives some support to McDonald's suggestions. Of the 104 children admitted to their homes during 1984 and 1985, the average age when first placed in care was



9.2 years and the average age of all children resident was 11.5 years. 76% of the children were boys and 43% were of Maori or Pacific Island origin. The primary reason for admission was parent- rather than child-related in 72% of cases. Most referrals came either from the family itself or from a general practitioner involved with the family (Salvation Army, personal communication).

The children admitted to care in voluntary institutions do, however, now tend to be older and to have more behavioral problems than was previously the case. Care and supervision of such children requires higher staffing ratios which are more expensive to maintain.

Resource usage

During the period 1973 to 1986, the proportion of the Department of Social Welfare's social-work spending which went on residential services dropped from almost 60% to under 30%. This reflects a very large increase in the funding of non-residential social work services, which rose from \$18,719,549 (expressed in 1986 dollar values) in 1972/73 to \$84,403,000 in 1985/86. Spending on residential services increased from \$25,786,782 in 1975 (1986 dollars) to \$48,115,933 in 1982; and since that time there has been a decline in the actual amount spent, to \$30,885,000 in 1985.

This drop in spending has been achieved despite an overall increase in the number of children being admitted into residential care. It has been possible because of the increased use of family homes which are much less expensive than other residential options, mainly because of lower expenses associated with staffing (Infogram 5.4).

The Department's capacity to make greater use of family homes is, however, limited to some extent by the need for more secure facilities for some young people, especially the growing number being admitted on remand. The impact of the Criminal Justice Act 1985, which came into effect on 1 October 1985 and which prohibits the remand of offenders aged 16 or under to prison, is difficult to foresee. A much greater number of young people are being referred from the courts and require secure short-term accommodation. The Department of Social Welfare expected to provide 400 places for young people remanded in custody in the first 12 months of the Act's implementation.

It is not possible to make completely valid comparisons of the costs between institutions. In many respects the different types of institutions serve quite different populations. National institutions, for example, cater for older children whose behaviour is of concern to society and who may have previously experienced other forms of care, including family homes. These children often need greater levels of security, associated with higher staffing ratios. Ordinary schools often have difficulty in adapting to such children who, as a consequence, are educated within the institution.

Childcare is a costly business and, though the level of support to voluntary institutions has increased, it compares unfavourably, for example, with the level of subsidy provided to voluntary organisations caring for the dependent elderly. As the voluntary sector's ability to provide residential care has declined, the state sector has had to assume a proportionately greater role.

Overall, the Department of Social Welfare appears, through a process of developing cheaper residential options which also more closely resemble "normal" family life, to have improved the efficiency of its residential services in terms of both cost and quality of service. The more careful planning for the future of children who come into the Department's care has also meant that fewer children are likely to be placed inappropriately in children's homes.

Effectiveness

Residential institutions provide shelter and care for children and young people whose families are unable to provide that care, and for whom no community-based care can be found. They also provide custodial care for children and young people who are either awaiting court hearings or who have been judged to be in need of greater control than their parents can exercise. The capacity of an institution to meet these goals without distortion in one direction or the other is doubtful, for there is an obvious tension between the function of care and that of custody.

There is widespread agreement that large institutions are least likely to have positive qualities but there are no conclusions as to optimum size. As far as possible the Department of Social Welfare and voluntary agencies seek to replicate the key elements of family life in their residential programmes. For this reason Department of Social Welfare family homes are restricted to a maximum of six children. As homes get larger there is a greater need for routines. In its larger homes the Department seeks to operate smaller internal units to avoid the more

Infogram 5.4

FINANCIAL COSTS TO THE DEPARTMENT OF SOCIAL WELFARE OF PROVIDING INSTITUTIONAL CARE FOR CHILDREN AND YOUNG PEOPLE
(Cost per bed for year ended 31st March 1985)



Sources: Department of Social Welfare, New Horizons, 1982,
Department of Social Welfare, unpublished data, 1985.

institutional procedures. Of particular concern has been the capacity of residential institutions to meet the needs of the large numbers of Maori and Pacific Island children admitted to them. A working party of the Department expressed reservations about the small number of staff from similar cultural backgrounds to these children and about the ability of the institutional environments to develop culturally appropriate programmes (Department of Social Welfare, 1985b).

Acceptability

In DSW's terms, institutional care is not the preferred type of care. Since 1925 placement in the community has been the goal, and institutional placement the least favoured option. In fact fostering, which is the traditional community placement, has declined in availability. In 1966, 48% of state wards were in foster care; by 1971 this proportion had dropped to 41% and has remained at that level. In 1966, 16% were living with relatives. This dropped to 10% in 1977 and has continued at that level. There are several reasons for this decline: until recent adjustments, financial support for foster parents was very limited; work patterns especially for women have changed; and there have been increasing numbers of state wards in the older age groups, which are not so popular with potential foster parents.

The public's ambivalence over the role of children's homes makes their acceptability a matter of shifting opinion. Among professionals, residential institutions are seen as the least preferred option in childcare, but as one that in some cases is unavoidable. It is thought by some workers that, for young people who are undergoing psychological difficulties, the emotional pressures of family life may be too intense and they are better off in the relative anonymity of group living. The importance of peer rather than family influence in adolescent development is also cited as an argument for group care.

The Department of Social Welfare has placed a greater emphasis on institutions as vehicles for social work rather than custodial care. Staff have more than just a custodial role. They are expected to help the children learn ways of adapting to the wider community. To this end, training of residential social workers has received greater emphasis in recent years. In 1986, 3% of residential social workers had a professional social work qualification, compared with 0.3% in 1979. However, this still compares unfavourably with the 31% of DSW field social workers who had professional social work qualifications in 1986. The Department of Social Welfare has sought to involve the community in the life of institutions. The reverse, involving the children in the community, is often not possible because of negative community attitudes towards children in residential institutions.

Given the clear indications of over-representation of Maori people in Department of Social Welfare homes, it is regrettable that the department does not routinely collect data on ethnicity.

Department of Social Welfare children's homes have their standards of service assessed by lay people in the form of visiting committees. These committees have had problems in developing an effective style of operation but in recent times some, at least, have taken on a clear advocacy role in respect of the children in the institutions.

Key Points

- * Although both the Department of Social Welfare and voluntary welfare agencies provide institutional care for children, neither have a preference for providing this type of care. Both prefer to provide community care whenever practical.
- * Numbers of children coming into Department of Social Welfare care have decreased in recent years.
- * Of the children coming into Department of Social Welfare care, only a minority are admitted into institutions. Most continue living with their parents or relatives or go into foster care.
- * Institutional admission is more likely for boys than girls, for Maori than for non-Maori, and for older children than for younger children.
- * In the past, voluntary agencies (and particularly churches) have had a strong tradition of providing institutional care for children in need. However, over recent years this activity has been declining. As a result the number of children admitted to institutions administered by voluntary agencies has dropped markedly.
- * Institutions are often thought of as places for "bad" children. However, admission to DSW or voluntary care is more often due to family circumstances than to the behaviour or personal characteristics of the child. With increasing age, though, behavioural problems (and particularly criminal behaviour) do become more significant as reasons for admission.
- * Family homes are the cheapest Department of Social Welfare institutions to operate, in terms of Department expenditure. They also seem to be the most effective and acceptable DSW institution. Generally the Department of Social Welfare has become more purposeful in its approach to children in care, and seems to be making more effective use of its resources. However, a shortage of adequate information is a major problem in making such assessments.

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CHAPTER 6: OTHER INSTITUTIONS FOR CHILDREN

Introduction

As well as hospitals and children's homes, there are a variety of institutions designed to meet the particular needs of certain groups of children. Special schools, health camps and boarding schools are discussed in this chapter. These institutions have as their only necessary common point the fact that they accommodate children: they are grouped more for convenience of presentation than because of a common identity.

Residential special schools

Some children have needs which, in order to be met, require the provision of special educational programmes. These needs may arise from physical disabilities, such as impaired sight or hearing, or from learning difficulties related to social, psychological or behavioural problems.

The education system provides a wide range of alternatives aimed at meeting the special needs of these children. Most special needs programmes are provided within the normal day-school structure, reflecting the current educational policy of "mainstreaming" wherever possible.

In some cases, however, children with special educational needs are referred to residential schools. Of the 9,773 pupils who were in special educational settings during 1983, only 867 (9%) were in special residential schools (Department of Statistics, 1984c). Further, the indications are that the number of pupils in such schools will decrease as more resources are devoted to "mainstreaming" (Department of Education, personal communication 1987).

Residential special schools are provided by either the Department of Education or by voluntary agencies who receive most of their funding for providing and operating these schools from the government. Infogram 6.1 provides details of the schools, and the nature of their pupils' special needs. As can be seen from this infogram, special residential schools fall into two main categories: those serving children with special needs resulting from physical impairment or handicap; and those serving children with special needs resulting from psychological, social or behavioural problems. Children in the latter category are referred to special schools when their problem is considered so severe that the child's continued presence in the "normal" community will severely disadvantage his or her educational attainment and future opportunities, or the opportunities of others with whom the child will mix.

Children are referred to special residential schools after assessment by professionals, most often educational psychologists, or by Department of Social Welfare social workers. Children whose behavioural problems are such that they are considered delinquent are cared for or controlled by the Department of Social Welfare rather than the Department of Education, and are unlikely to be referred to special residential schools.

The number of children with special needs, such as children with visual or hearing impairment, is relatively low. As a result, some special residential schools have developed as national or regional facilities, and children referred to them often

Infogram 6.1 SPECIAL RESIDENTIAL SCHOOLS IN NEW ZEALAND (1984/85)

PROVIDER	SCHOOL	NEED PROVIDED FOR	ROLL
State	Kelston School (Auckland)	Hearing impairment	55 (may include day pupils)
	• Van Asch College (Christchurch)	Hearing impairment	132 (may include day pupils)
	• Hogben School (Christchurch)	Learning difficulties	84
	• Salsbury Girls School Nelson	Learning difficulties	80
	• Campbell Park School Oamaru	Learning difficulties	104
	• Walmokola School (Auckland)	Maladjustment	32
	• McKenzie Residential School (Christchurch)	Maladjustment	25
	• Wilson Home (Auckland)	Physical handicap	64
Voluntary agencies	Homal College (Auckland)	Visual impairment	96 (may include day pupils)
	• Glenburn School (Auckland)	Maladjustment	31
	• Hohepa School (Clive)	Intellectual handicap	134
	• Birchfield Home School (Christchurch)	Intellectual handicap	
	• St Dymphna's Special School (Carterton)	Physical and Intellectual handicap	30
Total	All special schools	All special needs	867

Source: Department of Education, Directory of Special Education and Guidance Services in NZ 1984/85.

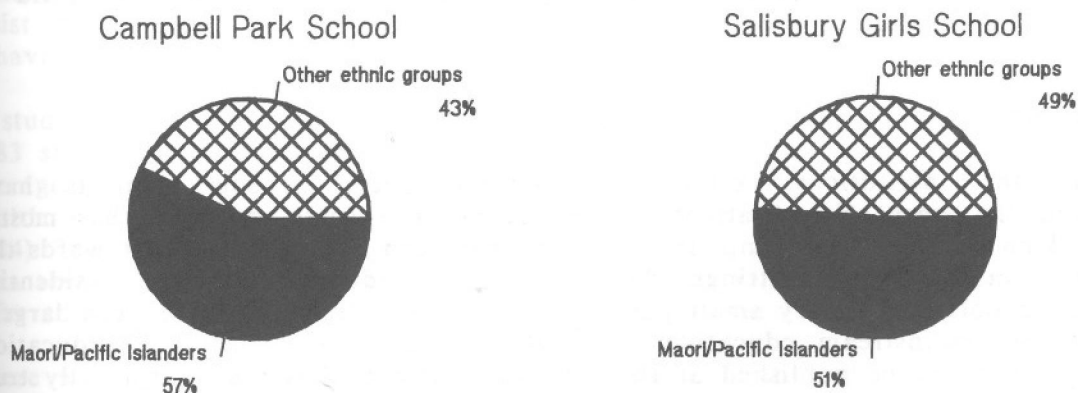
become residents of national institutions whether or not they are in need of total institutional care. Some schools, notably those catering for children with hearing or visual impairment, provide both residential and day facilities.

There is little information available about length of stay in residential special schools but it can be lengthy; for example the average stay in schools for slow learners has been reported as three years (Wilden and Rivers, 1980). Some schools, such as those for maladjusted children, provide schooling only up to second form level.

Information on the personal and family characteristics of children who attend special residential schools is not readily available. A count of pupils at Homai College, a special residential school for children with visual impairment, showed that the majority of pupils were European with some representation of other ethnic groups including Maori, Asians and Pacific Islanders (Royal New Zealand Foundation for the Blind, personal communication, 1985). The proportion of Maori and Pacific Island children in residential special schools for children with learning difficulties is, however, alarmingly high (Infogram 6.2) and has risen in recent years.

Why there should be so many Maori and Polynesian children in special residential schools for children with learning difficulties is not clear. The same trend is apparent for Maori children in special educational programmes within normal schools. In a review of special education, Wilton (1979) noted that the incidence of Maori children in special classes (in normal schools) was four times greater than expected. It is likely that this reflects the fact that learning difficulties can be the result of inadequate access to primary health care and good quality pre-school education. The fact, for instance, that Maori infants have an extremely high rate of hospitalisation for ear infections may have a detrimental effect on their later educational attainment. Further, their presence in special schools, and in educational programmes for slow learners, may reflect selective definitions of educational attainment and ability based upon cultural misunderstanding and racial stereotyping.

Infogram 6.2 ETHNIC COMPOSITIONS OF TWO DEPARTMENT OF EDUCATION SPECIAL SCHOOLS FOR CHILDREN WITH LEARNING DIFFICULTIES (1984)



Note: Data is not available for Hogben School, the third such special school.

Source: Department of Education (Special Education Section), unpublished data.

Resource usage

Residential special schools are expensive facilities to run, compared with other types of schools. As well as teaching staff they employ domestic, social work and specialist personnel, leading to a staff/pupil ratio of almost one to one.

The schools' estimated running costs for the financial year 1986/87 were \$10,150,000, with an overall cost per pupil of \$25,600. There is, however, considerable variation in costs between the schools, with Hogben at \$19,000 per pupil per year the lowest and Kelston at \$36,600 per pupil per year the highest (Havill, 1986). Why there is this difference is unclear. Hogben is a school in Christchurch for children with learning difficulties and Kelston is a school in Auckland for children with hearing impairments.

Effectiveness

The degree to which pupils are able to adjust to community and family life after discharge from a special school was described by a recent major review of residential special schools as the most important measure of the schools' effectiveness (Havill, 1986). By that standard, most of the schools have not been very effective. Pupils leaving schools for children with learning difficulties adjusted poorly in terms of obtaining employment. Only 11% were found to be in open employment in the most recent investigation. A study of leavers from schools for maladjusted children also showed little long-term benefit. By comparison, 45 of 47 school leavers from Van Asch college in 1984/85 were in open employment.

Impediments to effectiveness were identified as including: failure to recognize the multicultural nature of the clientele; insufficient work done with families; lack of specialist training for workers; under-utilisation of residential social workers; and the failure in many cases to develop a plan for the child before he or she was admitted to the school.

For all these schools, the ultimate test of their effectiveness should be whether the children's needs could have been met as effectively in normal schools or other community-based educational settings. Havill feels that this is possible for most children, but acknowledges that while the residential placement may not advantage the child it may have an important role in relieving pressures on others (particularly the child's usual carers and teachers) connected with the child in the "normal" community.

Acceptability

Of all the institutions examined, residential special schools seem to have received the least critical attention. Research on special education has mostly focused on particular learning strategies and has been directed mainly towards the children in day-school settings. Within the total education system, residential special schools are a very small part, and one which seems to have been largely ignored by mainstream educationalists until a recent Department of Education review (about to be published at the time of writing). This seems especially true of the schools for children with learning difficulties, perhaps because, unlike those children with physical impairments such as sight or hearing, they have no related formal associations of adults with similar handicaps or impairments, such as the New Zealand Foundation for the Blind.